

EXHIBIT D

GEORGE V. DIGIACINTO, M.D.
NEUROLOGICAL SURGERY

425 West 59th Street
Suite 4E
New York, N.Y. 10019
Phone: (212) 523-8500
Fax: (212) 523-8505

February 11, 2002

State of New York Worker's Compensation Board
P.O. Box 29017
Brooklyn, New York 11202-9017

RE: ANDRZEJ CIESILK
WCB CASE NO.: 00152055
DATE OF ACCIDENT: November 11, 2001
CARRIER CASE: 47294665-289
SOCIAL SECURITY NO.: [REDACTED]

Dear Gentlemen:

Mr. Ciesilk came to see me in consultation on February 11, 2002. This 49-year-old carpenter was working at the World Trade Center at the time of the catastrophe. He was thrown back striking, from his description, a marble column. He is not sure if had loss of consciousness at that time. He was able to escape from the building and was driving away when he stopped and then subsequently collapsed. He was taken to the hospital and later released. Since the time of the accident, he has not worked because of neck and bilateral arm pain on the right side. It goes to his shoulder and down to his elbow. On the left arm, it involves more of the shoulder. Neck activity, in fact any activity, exacerbates his pain. This has gradually gotten worse. He is on "pills" although he does not know what. He has not had any physiotherapy. He has been told that he may need a surgical procedure. He has had an MRI scan.

Past medical history is noncontributory. He says he is allergic to codeine, which "bothers my stomach". He has had an appendectomy. He smokes a pack a day. He says he has been drinking "too much to treat the pain".

Examination reveals a well-nourished, well-developed gentleman in moderate distress. Neck motion is full but causes him discomfort in all directions. He does not have the Lhermitte's sign by his report. Deep tendon reflexes reveal questionably decreased triceps circle on the left versus the right and a slightly decreased right biceps circle, although, this is variable. Motor testing is difficult secondary to pain. There was some question of triceps weakness on both sides, deltoid weakness bilaterally, although I think this was more secondary to pain. Sensation is grossly intact to pin and touch. There is no evidence of atrophy or fasciculation. An MRI scan reveals some degree of narrowing at C5-6 with bilateral foraminal encroachment and a soft disc herniation at C6-7, left greater than right.

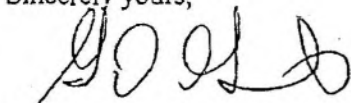
CIESILK, ANDRZEJ

-2-

February 11, 2002

I do think that Mr. Ciesilk's symptomatology is coming from the findings on the MRI scan. Based on the history available, there is a causal relationship between his problem and the accident of September 11, 2001. I have suggested that the patient might benefit from physiotherapy and evaluation by pain management with epidural steroids. Ultimately, he might require an anterior cervical discectomy at C5-6 and C6-7 with interbody fusion, probably autograft because of his smoking and anterior cervical plating. At this time, the patient is totally disabled. I would therefore request formal authorization for evaluation by physiotherapy, treatment by physiotherapy, evaluation and treatment by pain management, and I would like also to request authorization for anterior cervical discectomy and autogenous bone graft interbody fusion, C5-6 and C6-7 with anterior plating. I am hoping that this can be avoided; however, if he fails to respond to other modalities of treatment then I think he will become a surgical candidate.

Sincerely yours,



George V. DiGiacinto, M.D.

GVD/prn/GVD10814

cc: Noban Degani, M.D.



John I. Miller, M.D., F.A.C.S.
Richard W. Johnson, M.D., F.A.C.S.
Fred Nobandegani, M.D.
Harrison MU. T. M.D.

February 19, 2002

Re: CIESILK, ANDRZEJ

WCB Case#: 00152055
Carrier Case#: 47294665-289

Dear Sir/Madam:

I had the pleasure of seeing Mr. Ciesilk in my office for neurosurgical follow-up today. The patient returns with significant pain in the cervical spine and the upper extremities.

As I have previously alluded to, since the patient has failed all conservative management and due to pain and weakness in the upper extremities, I believe he is an excellent surgical candidate. The patient also was seen by Dr. George DiGiacinto, who is a neurosurgeon in Manhattan, for a second opinion. He also agreed that most likely the patient would be a surgical candidate, however a trial of pain management and physical therapy should be attempted first. I agree with Dr. DiGiacinto's opinion, and I strongly agree that should he fail these modes of conservative management, then anterior cervical discectomy with bone graft fusion and instrumentation is indicated.

I have taken the liberty of referring the patient for physical therapy, and I have also asked for a neurology evaluation with EMGs. As soon as the authorization is received and if the patient fails conservative management, it is the patient's decision where he would rather have the surgery be performed. I will continue to follow him on a p.r.n. basis.

Sincerely,

A handwritten signature in dark ink, appearing to read "F. Noban", written over a horizontal line.

Fred Noban, M.D.

FN/TL590/17840

ELECTROENCEPHALOGRAPHY (EEG)
ELECTROMYOGRAPHY (EMG)
NERVE CONDUCTION VELOCITY (NCV)
EVOKED POTENTIALS

PRACTICE LIMITED TO NEUROLOGY
BOARD CERTIFIED - PN (N)

BURTON S. DIAMOND
M.D., P.C.
650 CENTRAL AVENUE
CEDARHURST, L.I., NY 11516

TELEPHONE 516-569-2211

June 11, 2002

Crawford and Company
Melville Corporate Center
105 Maxess Road – Suite 229
Melville, New York 11747

Attn: Regina Adams
P.O. Box 9011

INDEPENDENT MEDICAL EVALUATION

RE: CIESLIK, Andrezej
FILE #: 56276938
CLAIM #: 98525048
DOA: September 11, 2001

To Whom It May Concern:

As per your request I performed an independent neurological examination on Andrezej Cieslik, a 47 year old male who was seen on June 11, 2002. A medical assistant was present for the interview and exam.

History: This man states that on September 11, 2001, during the terrorist attacks at the World Trade Center, this man was basically thrown against a wall and able to escape from the building. He states he fell down outside and was taken to the hospital. He apparently developed pain in his neck, right arm and elbow.

He came under the care of various physicians. He apparently never had physical therapy however. He had no surgical procedures.

Review of Medical Records: The following documentation was reviewed.

1. There is a report dated February 11, 2002 by Dr. Digiacinto, a neurosurgeon. He states that the claimant should have physical therapy, possible epidural steroids, possible cervical discectomy C5, C6, C7. He wanted authorization for physiotherapy and pain management and possible discectomy. On the examination he said motor

RE: CIESLIK, Andrezej
INDEPENDENT MEDICAL EVALUATION
June 11, 2002
Page: Two

- testing was difficult secondary to pain. He said a cervical MRI showed narrowing at C5-C6 with encroachment.
2. There is a cervical MRI dated January 3, 2002, showing anterior bulges, discogenic changes at C5-C6. There is foramina stenosis at C5-C6.
 3. There is a report by Dr. Noban, a neurosurgeon, dated February 19, 2002. He states that conservative management failed and that the claimant was an excellent surgical candidate. He recommended a neuro consult, physical therapy and EMG.

Descriptions of Current Complaints: At the present time he complains of neck pain and pain in the right upper arm. He also complains of right shoulder pain. There are no paraesthesias.

Job Description: He was a carpenter but has not worked since the incident. He is right-handed.

Past Medical History: He denies any previous history or symptoms.

General Physical Examination: This man stands 5'6", weighs 165 pounds. The claimant exhibits no antalgia on spontaneous movements. There was pain in the right shoulder on abduction. The neck showed no appreciable loss of range of motion.

Neurological Examination: The gait was normal. Tandem walking was normal. The Romberg was negative. Heel walking and toe walking were normal. There was no ataxia.

The arms and the legs showed normal muscle tone. There was no atrophy of any muscle group without exception. Strength was excellent in the proximal musculature of the upper extremities, biceps, triceps, brachial radialis, extensor group of the forearms. All were intact. The intrinsic hand muscles were fully intact, and there was no atrophy. Normal finger coordination. Strength in the legs including the pelvic girdle, quadriceps, hamstrings, extensor and flexor groups of the ankle and toes, and eversion were totally intact. No ataxia. Rapid alternating movements were fully preserved.

The biceps, triceps, knee jerks, ankle jerks were active and equal. The plantars were flexor. There was no clonus.

Double simultaneous stimulation was intact. Proprioception in the fingers and toes, pain sensation fully intact. Two point discrimination was intact in the fingers. Stereognosis was intact in the hands. Vibratory sensation was also intact.

Impression: Diagnosis possible cervical radiculopathy. The symptomatology is causally related to the incident. Physical therapy is indicated three times per week for the next eight weeks.

RE: CIESLIK, Andrezej
INDEPENDENT MEDICAL EVALUATION
June 11, 2002
Page: Three

At the present time I cannot state that surgery is definitely indicated at this time.

I would state he has a mild, partial disability for his activities and occupation. I would recommend that he be re-evaluated after physical therapy to see if at that time there is any permanency for the condition or whether further treatment is indicated, including surgical intervention.

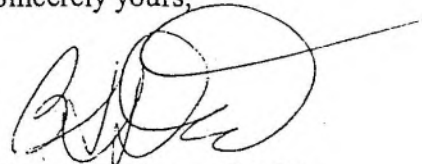
I would also allow an EMG of the right paraspinal muscles in the cervical region of the right arm.

To return to his prior occupation at this time is indeterminate.

I, Dr. Burton Diamond, being a doctor duly licensed to practice medicine in the State of New York, pursuant to the applicable provisions of the Civil Practice Law and Rules, hereby declare under the penalty of perjury that the information contained within this document was prepared and is the work product of the undersigned and is true to the best of my knowledge and information.

Pursuant to the CPLR Sec. 2106, and as a physician duly licensed to practice in the State of New York, I hereby affirm the truth of the foregoing.

Sincerely yours,

A handwritten signature in black ink, appearing to read 'B. Diamond', with a large, sweeping loop at the end.

Burton S. Diamond, M.D.
NYS License #09593

ELECTROENCEPHALOGRAPHY (EEG)
ELECTROMYOGRAPHY (EMG)
NERVE CONDUCTION VELOCITY (NCV)
EVOKED POTENTIALS

PRACTICE LIMITED TO NEUROLOGY
BOARD CERTIFIED - PN (N)

BURTON S. DIAMOND
M.D., P.C.
650 CENTRAL AVENUE
CEDARHURST, L.I., NY 11516

TELEPHONE 516-569-2211

October 1, 2002

Crawford and Company
Melville Corporate Center
P.O. Box 9011
Melville, New York 11747

Attn: Regina Adams

INDEPENDENT MEDICAL EVALUATION

CLAIMANT: CIESLIK, Andrzej
FILE #: 98525833
CRAWFORD #: 56279669
DOA : September 11, 2001

To Whom It May Concern:

As per your request I performed an independent neurological examination on Andrzej Cieslik, a 48 year old male, who was seen on October 1, 2002. A medical assistant was present for the interview and exam.

History: This gentleman was at the World Trade Center on September 11, 2001, during the terrorist attack. He was apparently thrown against the wall but he did get out of the building. He was complaining of pain in his neck and back and right arm. He was taken to a hospital and released. He has had no surgery up to now.

He continues with physical therapy twice per week.

Review of Medical Records: The following documentation was reviewed.

1. Noted is the fact that I saw this man for the first time on June 11, 2002. At that time I got the history and reviewed a report dated February 11, 2002 by a neurosurgeon. He recommended epidural steroids and possible cervical discectomy. I reviewed a cervical MRI dated June 3, 2002, showing foraminal stenosis at C5-C6 and a neurosurgical report dated February 19, 2002. He recommended EMG and possible

RE: CIESLIK, Andrzej
INDEPENDENT MEDICAL EVALUATION
October 1, 2002
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neurosurgery. At that time there was no deficit although I said he had a possible cervical radiculopathy and I recommended physical therapy. I said there was a mild, partial disability for his activities and occupation and that he should be reevaluated after physical therapy. I also said he could have an EMG of the right paraspinal muscles.

Job Description: He is a carpenter. He has not worked since the incident.

Past Medical History: He denies previous injury or symptoms.

Description of Current Complaints: He complains of neck pain radiating down the right arm with numbness and tingling of the first, second and third fingers. He states that despite the physical therapy, he still has the symptoms. He denies weakness in his legs or incontinence. He apparently never had epidural injections.

General Physical Examination: This man stands 5'6", 165 pounds. He has hazel eyes and brown hair.

This man was told that if any of the prescribed maneuvers evoked pain, he was to immediately stop performing the maneuver and inform me of the location of the pain.

He bends his neck 20 degrees back and forth and 60 degrees to the sides. Spurling's sign is equivocal.

Neurological Examination: The gait was normal. Tandem walking was normal. The Romberg was negative. Heel walking and toe walking were normal. There was no ataxia.

The arms and the legs showed normal muscle tone. There was no atrophy of any muscle group without exception. Strength was excellent in the proximal musculature of the upper extremities, biceps, triceps, brachial radialis, extensor group of the forearms. All were intact. The intrinsic hand muscles were fully intact, and there was no atrophy. Normal finger coordination. Strength in the legs including the pelvic girdle, quadriceps, hamstrings, extensor and flexor groups of the ankle and toes, and eversion were totally intact. No ataxia. Rapid alternating movements were fully preserved.

The biceps, triceps, knee jerks, ankle jerks were active and equal. The plantars were flexor. There was no clonus.

On the sensory exam there is decreased pin on the first, second and third fingers of his right hand. This is a very consistent finding apparently. It can be reproduced quite easily.

I note that when I saw this man previously, there was no deficit.

RE: CIESLIK, Andrzej
INDEPENDENT MEDICAL EVALUATION
October 1, 2002
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Diagnosis: The diagnosis is cervical radiculopathy on the right, most likely C5-C6, C6-C7. This involves the sensory roots.

Impression: Apparently this man has developed numbness in the right hand since I last saw him. This shows a progression of the cervical radiculopathy. It has not been helped by conservative physical therapy.

The symptomatology is related to the incident of September 11, 2001. He already had a cervical MRI that showed discogenic disease. I do not believe the physical therapy has been of any help at this time. I would state that at the present time, surgery is a reasonable procedure although it should be preceded by a cervical myelogram with a post myelogram CAT scan to see the exact distribution of the cervical lesion.

At the present time he is not working. He is right-handed and is a carpenter. His problem is in the right hand. I would state he has a moderate, partial disability for his occupation. It is too early to say whether there will be any permanency. However, I would state he could go back to his neurosurgeon for evaluation of surgical treatment.

I, Dr. Burton Diamond, being a doctor duly licensed to practice medicine in the State of New York, pursuant to the applicable provisions of the Civil Practice Law and Rules, hereby declare under the penalty of perjury that the information contained within this document was prepared and is the work product of the undersigned and is true to the best of my knowledge and information.

Pursuant to the CPLR Sec. 2106, and as a physician duly licensed to practice in the State of New York, I hereby affirm the truth of the foregoing.

Sincerely yours,

A handwritten signature in black ink, appearing to read 'B. S. Diamond', with a large, stylized loop at the end.

Burton S. Diamond, M.D.
NYS License #095943

Central Radiology Services, P.C.

Allen Rothpearl, M.D., MACR, DABR, Medical Director
 Daniel Schlusberg, M.D., MACR Associate Medical Director
 Charles DeMarco, M.D., MACR, DABR
 Charles Cooper, M.D., MACR, DABR

7901 Metropolitan Avenue
 Middle Village, NY 11379
 Voice (718) 326-2727
 Fax (718) 326-5837
 (718) 326-7250
 info@centralrad.com

December 13, 2002

Osric King, P.C.
 Sports Medicine
 176-60 Union TPK,
 Fresh Meadows, N.Y. 11366
 TEL: 718 591-5693
 FAX: 718 591-8919

PATIENT'S NAME: CIESLIK, ANDEREZI
 FILE NO. : 30822
 DATE OF EXAM : 12/12/02

Dear Dr. King:

Enclosed please find results of the following examination on the above patient.

MRI OF THE RIGHT SHOULDER:

Coronal T₁ and dual-echo acquisitions were obtained as well as an axial STIR acquisition.

There is marked productive change seen at the acromioclavicular joint which is effacing the subdeltoid fat plane and encroaching on the supraspinatus muscle tendon complex. There is a full thickness tear of the supraspinatus tendon at its distal aspect 2 cm proximal to its greater tuberosity insertion site. There is also a regional effusion. The infraspinatus tendon and subscapularis muscles and tendons are intact. The visualized osseous structures demonstrate normal marrow signal characteristics. The glenohumeral joint is normally maintained. The glenoid labrum are intact. The biceps tendon is of normal morphology, location and signal characteristics.

IMPRESSION:

1. MARKED PRODUCTIVE CHANGE AT THE ACROMIOCLAVICULAR JOINT WHICH IS ENCROACHING ON THE SUPRASPINATUS MUSCLE TENDON COMPLEX.
2. FULL THICKNESS TEAR WITH 2 CM OF RETRACTION OF THE SUPRASPINATUS MUSCLE TENDON COMPLEX.
3. JOINT EFFUSION.

Thank you for the courtesy of this referral.

Very truly yours,

ALLEN ROTHPEARL, M.D.
 Diplomate, American Board of Radiology

ELECTROMYOGRAPHY REPORT
Hospital for Special Surgery
 535 East 70th Street, New York, NY 10021

Patient: Andre Cielsik

Sex: Male

Date: 1/3/03

Nerve Conduction Report:

Motor Nerves

Nerve	Site	Onset Lat. (ms)	Amp (mv)	Distance (cm)	Velocity (m/s)
L Median	APB				
	Wrist	4.22	6.54	22.0	49.4
	AEIbow	8.67			
R Median	APB				
	Wrist	5.02	2.04	22.0	47.9
	AEIbow	9.61			
L Ulnar	ADM				
	Wrist	3.42	5.68	24.0	56.3
	Belbow	7.69			
R Ulnar	ADM				
	Wrist	3.09	8.80	21.0	46.7
	Belbow	7.59			

Sensory Nerves

L Median	2nd Dig	3.91	22.76 (uv)	14.0
L Ulnar	5th Dig	3.75	17.71 (uv)	14.0
L Radial	1st Dig	3.16	14.52 (uv)	10.0
R Median	2nd Dig	3.81	23.71 (uv)	14.0
R Ulnar	5 th Dig	4.28	23.31 (uv)	14.0
R Radial	1 st Dig	2.84	10.89 (uv)	10.0

Patient: Andre Cieslik**Date: 1/3/03****EMG Report:**

Side	Muscle	INS	FIBS	PSW	FAS	AMP	DUR	CONFIG	REC INT
L/R	Deltoid	Nml	0	0	0	Nml	Nml	Full	NmL
L/R	Biceps	Nml	0	0	0	Nml	Nml	Full	NmL
L/R	Triceps	Nml	0	0	0	Nml	Nml	Full	NmL
L/R	PTeres	Nml	0	0	0	Nml	Nml	Full	NmL
L/R	BrachioRad	Nml	0	0	0	Nml	Nml	Full	Nml
L/R	FCU	Nml	0	0	0	Nml	Nml	Full	Nml
R	Cerv Para								
	High	Nml	0	0	0	Nml	Nml	Full	Nml
	Mid	Inc	+2	+3	0	Nml	Nml	Full	Nml
	Low	Inc	+2	+3	0	Nml	Nml	Full	Nml

Clinical History: Neck Pain. Right Arm and Hand Pain.
Rule out Cervical Radiculopathy.

Summary of Electrophysiological Data:

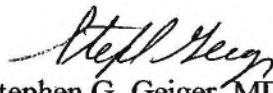
Motor nerve conduction studies of the upper extremities demonstrated a prolonged distal latency and low amplitude of the right median nerve. The velocity of the right median and ulnar nerves is slower compared to the left side.

Sensory nerve conduction studies of the upper extremities revealed prolonged distal latency of the right median and ulnar sensory nerves..

Needle EMG examination of the cervical paraspinals and upper extremities revealed increased insertional activity with acute denervation in the middle and lower cervical paraspinal muscles on the right side.

Impression: 1. There is electrophysiologic evidence of an acute cervical radiculopathy with acute denervation in the C6, C7, C8 nerve roots on the right side.

Thank you for the courtesy of this referral.


Stephen G. Geiger, MD
Diplomate of the American Board of
Physical Medicine and Rehabilitation

Greenpoint Cardiac & Medical Services, P.C.

145 Nassau Avenue Brooklyn, N.Y. 11222

Tel: 718.389-6575, Fax: 718.389-4977

ECHOCARDIOGRAPHIC STUDY: 2D, M Mode, Doppler: color, pulse, continuous.

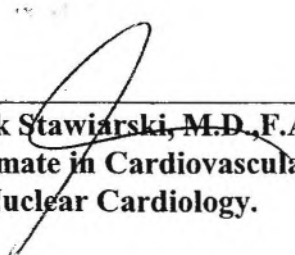
Name: Cieslik, Andrzej	Date: 01-29-03	Tape: 65
Log: 3482	Indication: LV function	Ref. Phys: Kramarczyk, M.D.

Measurements

LV diastolic dimension (normal up to 6.0cm)= 4.81cm	LV systolic dimension (normal up to 4.0cm)= 3.19cm
Septal thickness (normal up to 1.1cm)= 1.1cm	RV dimension (normal up to 3.8cm)= 1.58cm
Aortic root dimension (normal up to 3.9cm)= 3.7cm	Left atrial dimension (normal up to 4.1cm)= 2.8cm

1. Left ventricular cavity size and wall motion are normal. Ejection fraction is 56 %.
2. Right ventricular size and wall motion are normal.
3. Left atrial size is normal.
4. Right atrial size is normal.
5. Mitral valve apparatus is normal.
6. Aortic valve is tricuspid.
7. Aortic root size is normal.
8. Pulmonic and tricuspid valves are normal.
9. There is no pericardial effusion.
10. Intracardiac Doppler is normal.

IMPRESSION: Normal study.


Marek Stawiariski, M.D., F.A.C.C.
Diplomate in Cardiovascular Disease
and Nuclear Cardiology.

Answorth Allen, M.D.
The Hospital for Special Surgery
535 East 70th Street
New York, NY 10021
(212)606-1447

Dear Mr. Cieslik:

Dr. Allen has recommended a surgical procedure, which has been scheduled at The Hospital for Special Surgery on Jan 31, 2003. To avoid unnecessary delay, we ask that you read and follow these instructions carefully:

Before surgery:

1. Prior to surgery, you will need to have a pre-admission examination & clearance.

We have arranged to have you see

Dr. Osric King date Jan 27, 2003.

The office address is 176-60 Union Tpk, Fresh Meadows, NY The phone number (main # in Queens) is 718-591-5693

Only if your primary physician is affiliated with New York Hospital here in New York City, can you see your own doctor. Our hospital has strict pre-operative medical guidelines, and otherwise, this exam must be done by a Hospital for Special Surgery physician.

Please bring a list of all medications you may be taking, as well as any previous physician's telephone numbers you have consulted for your other conditions.

Someone from The Hospital for Special Surgery's ambulatory surgery department will call you after 12:00 the day before surgery, to give you last minute instructions and to tell you what time you are to report. If you do not hear from them by 5:00 PM, please call the nurse at 212-606-1154.

If you have x-rays or MRIs in your possession, please bring them the day of surgery.

- 2.) If you need letters for work, disability forms and supplemental insurance forms filled out and signed, please give these to us approximately **1 week before the date that you actually need them**. We try to do these forms as quickly as possible, it is often difficult to do them on demand.

After surgery:

1. Following your surgery, you may receive bills from Dr. Allen, the hospital and the anesthesiologist. This office is responsible for providing you with itemized bills for Dr. Allen's services or in helping you complete your insurance forms.
2. Post-operatively, you will be scheduled for 2 appointments, the first being approximately 10 days following your surgery. The second visit will be approximately 5 weeks after surgery. Your first postop date will be Feb 10, 2003 at 1:30pm for checkup & stitch removal. Please call the office on the next business day following your surgery for instructions on

212 774 2280

physical therapy start dates. (Start dates will depend on the type of surgery that you have. Many surgeries start therapy a day or 2 after surgery.)

3. You should receive post-operative instructions, prescriptions for pain medication in the recovery room following your surgery. If you would like this phoned into your pharmacy a day or two before surgery, call the office with your pharmacy phone number.

If you have any questions, please feel free to contact me at the above telephone number.

Amy Gilcrest, Office manager

**THE HOSPITAL FOR SPECIAL SURGERY
OPERATIVE RECORD**Patient Name: CIESLIK, ANDRZEJDate: 01/31/2003 Service:MR# 782930

ATTENDING SURGEON:

ANSWORTH ALLEN, M.D.

OPERATING SURGEON:
ASSISTANT:ANSWORTH ALLEN, M.D.
BENJAMIN MA, M.D.

PRELIMINARY DIAGNOSIS:

RIGHT SHOULDER ROTATOR CUFF
TENDON REPAIR, RIGHT SHOULDER
IMPINGEMENT, ACROMIOCLAVICULAR
JOINT ARTHRITIS.

POSTOPERATIVE DIAGNOSIS:

SAME.

NAME OF OPERATION:

RIGHT SHOULDER ARTHROSCOPY,
DEBRIDEMENT OF THE ANTERIOR
LABRUM, ARTHROSCOPIC
ACROMIOPLASTY, ARTHROSCOPIC
ACROMIOCLAVICULAR JOINT EXCISION,
ROTATOR CUFF TENDON REPAIR USING
AN ARTHROSCOPICALLY ASSISTED
TECHNIQUE.

ANESTHESIA:

INTERSCALENE BLOCK.

COMPLICATIONS:

NONE.

ESTIMATED BLOOD LOSS:

LESS THEN FIVE CC.

FLUIDS:

700 CC RINGERS LACTATE.

FINDINGS:

At the time of examination under anesthesia the patient had full range of motion of the shoulder with no ligamentous instability. At the time of arthroscopy had some free movement of the anterior labrum. The biceps looked to be in good position. There was a fair amount of bursitis in the subacromial space. He had a moderate size acromial spur. He had an arthritic acromioclavicular joint. The rotator cuff

THE HOSPITAL FOR SPECIAL SURGERY OPERATIVE RECORD

Patient Name: CIESLIK, ANDRZEJ

Date: 01/31/2003

Service:

MR# 782930

tendon was torn, and was retracted approximately 15 mm. The tear measured about 1 x 2 cm.

PROCEDURE:

The patient was brought to the Operating Room. After successful interscalene block, examination under anesthesia of the right shoulder was done with findings as noted above. The right shoulder and right upper extremity were prepped with Betadine and draped in the usual sterile fashion. A standard posterior portal was made and diagnostic arthroscopy was performed with findings noted above.

An anterior portal was established. This was used to debride the superior labrum. The subacromial space was then entered and bursectomy was performed through the anterior portal, distal one cm of clavicle was resection. The amount of resection was confirmed with intraarticular placement of spinal needles. The acromion was resected and the greater tuberosity was debrided back to bleeding bone. An Arthrex was placed in the tuberosity, and two single sutures were placed through the rotator cuff, which was then tied back anatomically to the tuberosity. This facilitated a complete water tight repair of the rotator cuff tendon.

The arthroscopic equipment was removed. The portals were closed. Dressings were placed. The patient was transferred from the Operating Room to the Recovery Room in stable condition.

DATE

ANSWORTH ALLEN, M.D.

CC: ANSWORTH ALLEN, M.D.
ANSWORTH ALLEN, M.D.

Dictated by: ANSWORTH ALLEN, M.D./ANSWORTH ALLEN, M.D.

Dict Date: 02/18/2003 Typed by: PMC/PB/08275 Trans Date: 02/18/2003

**HOSPITAL
FOR
SPECIAL
SURGERY**

 535 East 70th Street
New York, NY 10021

**SHOULDER ARTHROSCOPY
DISCHARGE INSTRUCTIONS**

 78-29-30 M
CIESLIK, ANDRZEJ A
AMSOR WCOMP SELF P 01/31/03
ALLEN, ANSWORTH A
72646964

The following guidelines will help you have a speedy recovery. Following the surgery, your shoulder will be covered with a dressing. Your arm will be elevated in a sling or shoulder immobilizer.

DIET: You may resume your regular diet as tolerated. Avoid alcoholic beverages.

MEDICATIONS: Your physician has prescribed the following medications: Vicodin Vioxx Tigan

INSTRUCTIONS:

KEEP incision clean and dry
(P) SHOULDER IN SLING AT ALL TIMES

ACTIVITIES: Wear your immobilizer/sling at all times or as directed by your physician.

Please consult your physician or attached instruction sheet as to whether you may remove it for showering/dressing/sleeping.

Please consult your physician or attached instruction sheet for specific types of exercises and when to begin them.

Apply ice to surgical site 20 minutes 4 times a day. If you have a shoulder cryo cuff please follow the instructions for the cryo cuff.

It is advisable to rest 1-2 days or as directed by your physician.

The length of time for your anesthesia to wear off will vary. Your anesthesiologist will estimate this time. Please be sure to protect your ulnar nerve (funny bone). You can do this by: Padding your elbow area on pillows, keeping your arm in a normal position, and not sleeping on your arm.

LIMITATIONS: Avoid activity with your operative arm. Resume activity/rehabilitation as directed by your physician.

Keep operative site clean and dry. Wash axillary area daily. Remove dressing as instructed by your physician.

Do not drive a car or operate heavy machinery until cleared to do so by your physician.

WARNINGS: Contact your physician if you have any of these symptoms:

- a) Bleeding through the dressing.
- b) If you are excessively dizzy and have difficulty standing.
- c) Excessive vomiting.
- d) Numbness or tingling in your arm that does not resolve within 24 hours.
- e) Fever or chills.
- f) Change in color or temperature of your arm/hand.

If you are unable to reach your physician and the symptoms persist, go to the nearest hospital emergency room.

Call your physician for your follow up visit. If you have any other questions, contact the Ambulatory Surgery Center from 8:00AM-5:00PM Monday thru Friday at

DR ALLEN'S OFFICE 212-606-1205
TELEPHONE NUMBER

Please adhere to any specific instructions your physician may give you regarding your recovery and rehabilitation.

WORK OR SCHOOL: YOU MAY RETURN AFTER _____ DAYS

OTHER INSTRUCTIONS:

I hereby accept, understand and can verbalize these instructions.

Signature of Patient or Significant Other _____

Relationship _____

Date 3.1.03 M.D. Signature _____

R.N. Signature KLH

Flushing
176-60 Union Turnpike, Ste 42 B
Flushing, NY USA 11366
Phone: (718) 591-3000 Fax: (718) 591-3004

Acct #: 050403010086
Physician: Amsworth A. Allen
Clinician: Lauren Wright
Inj. Date: Sep 11, 2002
Surg. Date: Jan 31, 2003
Visits: 1 Cxl/Ns: 0

Patient: [REDACTED]
Visit Date: Feb 4, 2003
SSN: [REDACTED]
FSC: Workers Compensation
Payer: Crawford & Co
Pol\Claim#: 00152055
Employer: Carpenter & Joinel Local 608
Case Mgr: Susan Chotkin

Initial Evaluation

Diagnosis Right Shoulder 71941 Pain, Shoulder

Subjective Examination

ADL/Functional Status:

- Current Work Status: Unable to Work Secondary to Dysfunction. Premorbid Work Status: Full Time/Full Duty. Current Basic Care: Moderate Assistance Required. Premorbid Basic Care: Independent Without Difficulty.

Extremity Dominance:

- Right.

Mechanism of Injury: Primary Episode: Date of Injury:

- Date 09/11/2001

Medical History:

- Questionnaire completed, reviewed and on file.

Medical Management: Surgery: Rotator Cuff: Arthroscopic Repair:

- 1st Surgery 01/31/2003

Medical Management:

- Immobilization/Splint/Fixation: Sling.
- Medications: Prescription:
 - Muscle Relaxers. Pain Medication/Analgesics.

Objective Examination

Grip/Pinch Strength:

- Grip Dynamometer I

Left
80.0 Pounds

Right
15.0 Pounds

Muscle Performance:

- Abduction
- Elbow Extension
- Elbow Flexion
- Extension
- External Rotation
- Flexion
- Internal Rotation
- Scapular Elevation
- Scapular Protraction
- Scapular Retraction

Right

+1 /5
3 /5
2 /5
2 /5
2 /5
+1 /5
2 /5
+3 /5
3 /5
+3 /5

Observations:

- Ecchymosis: Mild. stitches are still intact, no drainage noted

Range of Motion:

- Abduction
- External Rotation - 0 deg
- Horizontal Abduction
- Internal Rotation - 0 deg

R. Act.

20
0
30
30

Treatments

Exercise Activities: Isometrics:

• -Gripping	Time Elapsed (Min): 5, Repetitions: 1, Technique: Theraputty.
Modalities:	
• Cryotherapy	Time Elapsed (Min): 15, Location: Anterior/Posterior, Clinical Use: Post Activity.
• High Voltage Stimulation	Time Elapsed (Min): 15, PPS: 120, Location: Medial/Lateral, Mode: Continuous, Clinical Use: Post Activity.
Treatment Guidelines:	
• Restrictions!	Activity I: Passive ROM Only.

Assessment

In my professional opinion, this client requires skilled rehabilitative therapy in conjunction with a home exercise program to address the problems and achieve the goals outlined below. Overall rehabilitation potential is good. The patient and/or family were educated regarding their diagnosis, prognosis and related pathology. The client exhibits fair understanding and performance of the therapeutic activity and instructions outlined in this skilled rehabilitation session.

Evaluation Components:

- Expected Treatment Duration: 4 months

Impairments Identified:

- Aerobic Capacity. Joint Mobility. Muscle Performance. Range of Motion. Posture. Pain. Flexibility. Soft tissue mobility. Swelling.

Problems & Goals

Problem #1 ADL/Functional Status: Current Work Status: Unable to Work Secondary to Dysfunction.

LTG: 3 Months Functional Improvements In:
• Work Capacity, Returning to: Full Time/Unrestricted Duty.

Problem #2 ADL/Functional Status: Current Basic Care: Moderate Assistance Required.

LTG: 3 Months ADL Improvements In:
• Overall Function to Pre Morbid Levels.

Problem #3 Range of Motion.

LTG: 3 Months	Range of Motion Improvements to: Shoulder:	R. Act.
	• Abduction	170
	• External Rotation - 0 deg	65
	• External Rotation - 90 deg	80
	• Flexion	170
	• Internal Rotation - 0 deg	60
	• Internal Rotation - 90 deg	70

Problem #4 Muscle Performance.

LTG: 3 Months	Musculoskeletal Improvements In: Manual	Left	Right
	Muscle Strength to:		
	• Abduction	5/5	5/5
	• Elbow Extension	5/5	5/5
	• Elbow Flexion	5/5	5/5
	• Extension	5/5	5/5
	• External Rotation	5/5	5/5
	• Flexion	5/5	5/5
	• Internal Rotation	5/5	5/5
	• Scapular Protraction	5/5	5/5
	• Scapular Retraction	5/5	5/5

Problem #5 Grip/Pinch Strength.

LTG: 3 Months	Musculoskeletal Improvements In: Grip/Pinch	Right
	Strength To:	
	• Grip Dynamometer I	80.0 Pounds

Plan

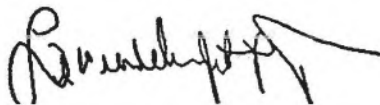
The goals and plan were discussed with the client and/or family and they concur. Instructions included to call regarding problems or questions. It is recommended that the client attend rehabilitative therapy three times a week.

Projected Duration:

- 12 weeks

Therapeutic Contents:

- Client Education. Home Exercise Program. Passive Range of Motion Activities. Manual Range of Motion Activities. Active Assistive Range of Motion Activities. Active Range of Motion Activities. Stretching/Flexibility Activities. Proprioceptive/Closed Kinetic Chain Activities. Aerobic Conditioning: Upper Body Ergometer. Joint Mobilization Techniques. Soft Tissue Mobilization Techniques.
- Resistive Activities:
 - Isometric. Isotonic. Tubing/Bands. Theraputty. Pulleys. Machines/Free Weights. PNF.
- Modalities:
 - Cryotherapy. High Voltage Stimulation. Ultrasound. Moist Hot Pack.



Lauren Wright, PT(NY Lic: 021941-1)

ANSWORTH A. ALLEN, M.D.

CIESLIK, ANDEREZI

=====

POST-OP VISIT: 02/10/03

Mr. Cieslik comes in today for his 1st post-op visit. He's status post arthroscopic rotator cuff tendon repair, acromioplasty, and AC joint excision. Sutures were removed and the wound is healing well. He has excellent passive ROM of the shoulder.

PLAN

To continue with PT.

Sports Physical Therapy of New York, P.C.

MANAGED BY HEALTHSOUTH

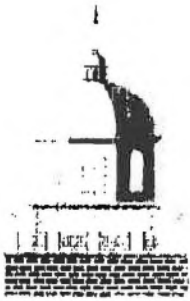
176-60 Union Turnpike, Suite 42 • Flushing, NY 11366 • 718 591-3000 • Fax 718 591-3004

Empire State Occupational Therapy, P.C.

MANAGED BY HEALTHSOUTH

Formerly Professional Sports Care

<input type="checkbox"/> Progress Report		<input type="checkbox"/> Discharge Summary	
Dear Doctor: <u>To Whom it may Concern</u>		Date: <u>2/20/03</u>	
Patient Name: <u>Andrzej Cieslik</u>		Diagnosis: <u>RTC Repair</u>	
Treatment Start Date: <u>2/20/03</u>	Last Treatment Date: <u>2/20/03</u>	No. of Treatments Given: _____	Cancel / No Show: _____
Status: <input type="checkbox"/> WORSE <input type="checkbox"/> SAME <input checked="" type="checkbox"/> IMPROVED <input type="checkbox"/> HAS RECEIVED MAXIMUM BENEFIT			
TREATMENT SUMMARY			
<p>Currently pt is only allowed to move his arm @ elbow/wrist. Passive motion only @ shoulder. Rx has focused on the above issues.</p>			
OBJECTIVE PROGRESS / GOALS MET TO DATE			
<p>ROM - see evaluation [90° ✓ 65° abd BLDR NT]</p> <p>Active movement @ shoulder not allowed @ this time. Pt reports pain @ anterior aspect of shoulder @ night and after stretching.</p>			
REMAINING THERAPY GOALS:			
<p>ROM / PROM to pre-morbid levels.</p> <p>↑ Strength to pre-morbid levels.</p> <p>↓ Pain to 0/10.</p>			
PLAN OF CARE			
<p>Progress per physician orders.</p> <p>It will be another 3 wks before pt allowed to actively move arm.</p>			
REHAB POTENTIAL: <input checked="" type="checkbox"/> POOR <input type="checkbox"/> FAIR <input type="checkbox"/> GOOD <input type="checkbox"/> EXCELLENT <input type="checkbox"/> UNKNOWN			
COMMENTS:			
Expected rehab duration is @ 4 months			
PT SIGNATURE: <u>[Signature]</u>		LICENSE # _____	
PHYSICIAN'S REQUEST: I certify that the above rehabilitative services are required and authorized by me, and that the patient's plan will be reviewed every thirty (30) days.			
<input type="checkbox"/> Continue Rehabilitation for _____ weeks at <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 days per week (check one)			
<input type="checkbox"/> Then Reduce Frequency for _____ weeks at <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 days per week (check one)			
<input type="checkbox"/> Discharge from Rehabilitation			
Revisions: _____			
<input type="checkbox"/> NONE - Continue under Therapist's Discretion			
Additional Comments: _____			
PHYSICIAN'S SIGNATURE _____		DATE _____	

**METROPOLITAN DIAGNOSTIC IMAGING, P.C.**

601 Franklin Avenue • Suite 100 • Garden City, NY 11530

Tel: 516-747-0161 • Fax: 516-747-0166

OPEN MRI

224 Seventh Street • Garden City, NY 11530

Tel: 516-877-9700 • Fax: 516-877-9701

Lowell B. Barek, M.D.

Sheldon P. Feit, M.D.

Patricia Kelly, M.D.

David R. Payne, M.D.

Ronald Schwinger, M.D.

April 7, 2003

Stephan G. Geiger, M.D.
333 Earle Ovington Boulevard, Suite 106
Uniondale, NY 11553

Dear Dr. Geiger:

RE: CIESLIK, ANDRZEJ
DOB: [REDACTED] 1954

MRI OF THE CERVICAL SPINE 04/05/03:

An MRI of the cervical spine was performed. Multiple T1 and T2 weighted sagittal images were obtained using a conventional and fast spin-echo pulse sequence. Partial flip angle axial images were also obtained.

FINDINGS:

There is straightening of the cervical lordosis. The cervical vertebral bodies are normal in height. There are no compression fractures or subluxation. The craniocervical junction is normal. There is no evidence of tonsillar ectopia. There are reactive end plate changes at the C5-6 level. There are degenerative spondylitic changes with anterior osteophytic spurring at the C4-5, C5-6, and C6-7 levels. There is desiccation of all the cervical intervertebral discs. At the C6-7 level, there is a large broad based, left sided disc herniation with a severe central canal left exit foraminal stenosis and cord compression. There are bulging discs at the C3-4 and C5-6 level. At the C5-6 level, there is posterior osteophytic spurring which in combination with the bulging disc results in a mild to moderate central canal and bilateral exit foraminal stenosis. There is mild effacement of the ventral aspect of the cervical cord at this level but no frank cord compression. The cervical cord demonstrates normal signal intensity without evidence of abnormal T2 brightening or syrinx. The paraspinal soft tissues are normal.

IMPRESSION:

1. LARGE BROAD BASED LEFT SIDED DISC HERNIATION AT THE C6-7 LEVEL WITH SEVERE SPINAL STENOSIS AND CORD COMPRESSION.
2. DESICCATED BULGING DISC AT C5-6 WITH POSTERIOR OSTEOPHYTIC SPURRING AND ASSOCIATED SPINAL STENOSIS WITH MILD EFFACEMENT OF THE CERVICAL CORD.
3. MILD DISC BULGE AT C3-4.

Thank you for this referral.

Sincerely,

Patricia Kelly, M.D.
PK/aa



PAUL TARTELL, MD FACP, DABR, Founder
 CRAIG L. YOUNGER, MD FACP, DABR
 JAY D. TARTELL, MD MACH, DABR
 PETER KRATKA, MD MACH, DABR
 BETSY JACOBI, MD MACH, DABR
 DAVID A. GREEN, MD MACH, DABR
 MARJORIE M. STEIN, MD MACH, DABR
 ALAN J. ROPE, MD MACH, DABR

**ADVANCED RADIOLOGICAL
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 29-16 Astoria Boulevard
 Astoria, NY 11102-1742
 Tel: (718) 204-5800
 Fax: (718) 721-4572

**ADVANCED RADIOLOGICAL
 IMAGING ASSOCIATES, P.C.**
 89-40 56th Avenue
 Elmhurst, NY 11373-4943
 Tel: (718) 335-5532
 Fax: (718) 426-9266

**ADVANCED RADIOLOGICAL
 PET IMAGING, P.C.**
 23-34 30th Avenue
 Astoria, NY 11102
 Tel: (718) 204-7774
 Fax: (718) 204-6967

July 10, 2003

Dr. A. Allen
 535 East 70th Street
 New York, NY 10021

Re: Cieslik, Andrzej
 Astoria Office
 DOB: [REDACTED] 54
 Acct. # 224557

MBI RIGHT SHOULDER:

Axial, proton density, fat saturated fast spin echo, coronal oblique T1, proton density fast spin echo, fat saturated, and STIR and sagittal T1 weighted images were performed. A scout sequence which is gradient echo axial was also performed.

There is metallic susceptibility artifact in the region of the greater tuberosity of the proximal humerus consistent with known history of prior rotator cuff surgery. There is edema in the posterior supraspinatus tendon adjacent to the greater tuberosity insertion. There is a 1.5 cm gap in the posterior supraspinatus tendon consistent with a partial full thickness tear. The supraspinatus muscle is not atrophic or retracted. The infraspinatus and subscapularis tendons are intact.

There is no abnormal signal from the bones. There is low-lying acromion and distal clavicular head impinging slightly on the supraspinatus. There is no effusion in the shoulder joint. There is a small effusion in the subacromial/subdeltoid bursa. The glenoid labra are intact. The long head of the biceps tendon has a normal configuration and position.

IMPRESSION:

Status post surgery to the region of the insertion of the supraspinatus on to the greater tuberosity. There does appear to be a partial full thickness tear of the posterior supraspinatus tendon. There is a small effusion of the subacromial/subdeltoid bursa.

Thank you for the courtesy of this referral.

Sincerely,

J. D. T.
 Jay D. Tartell, M.D.

JDT/sm

FAXED
 7/14/03

Bernard A. Rawlins, M.D.
THE HOSPITAL FOR SPECIAL SURGERY
 535 EAST 70TH STREET
 NEW YORK, NEW YORK 10021
 (212) 606-1632

ANDRZEJ CIESLIK	HSS:	78-29-30
59-53 56 RD	AGE:	48
MASPETH, NY 11378	DOB:	██████ 1954
H: 718-326-7884	REF:	ANSWORTH ALLEN, M.D.
B:		

<u>INITIAL VISIT</u>	SEPTEMBER 3, 2003
-----------------------------	--------------------------

HISTORY OF PRESENT ILLNESS

The patient is a forty-eight year old gentleman with right shoulder pain that started after September 11, 2001 following the terrorist attack at the World Trade Center where he was working at that time in the lobby of the second floor. He states that because of continued right shoulder pain he underwent surgery by Dr. Answorth Allen for repair of a muscle and reattachment of the portion of his right shoulder. He initiated physical therapy and about two to three months later he had increasing right shoulder symptoms and because of concern that this was a result of neck complaints, he was referred by Dr. Allen to me for further evaluation. An MRI was done which shows severe spinal stenosis and cord compression at the C6-7 level performed April 7, 2003. Dr. Allen performed an MRI of the shoulder and the patient states that he is considering revision shoulder surgery for detachment of tissue in the shoulder. The patient is complaining of paresthesias, numbness affecting the third, fourth and fifth digits of both upper extremities.

MEDICAL HISTORY

Denies any cardiac or pulmonary disease.

SURGICAL HISTORY

Right shoulder surgery January 2003 by Dr. Allen.

ALLERGIES

None.

MEDICATIONS

PCN.

SOCIAL HISTORY

Married, three children, smokes a pack of cigarettes a day, drinks occasionally and is a carpenter by profession.

SEPTEMBER 3, 2003

-2-

ANDRZEJ CIESLIK

PHYSICAL EXAMINATION

He has weakness most notably of the wrist flexor on the right side and triceps. The deltoids and internal and external rotation of the shoulder appears strong but is difficult to evaluate secondary to his recent shoulder surgery. The sensation is grossly intact, reflexes are symmetric at the biceps, and triceps, no pathological reflexes are not noted.

RADIOGRAPHS

AP lateral of the cervical spine shows a cervical spondylosis. The actual MRI is not available for review. However, the report does suggest severe stenosis at C6-7 with a broad disc with cord compression.

IMPRESSION

Cervical stenosis.

PLAN

I have asked the patient who states that he is trying to obtain the actual MRI films and he should return once he obtains these and come back to see me next week where I can review this. I also feel that it is a good idea to get a good neurological examination and I would like to have him seen by Dr. Carl Heise. If there is significant cord compression this will need a decompression but we will need the actual MRI to be able to review this study. Otherwise, a repeat MRI will be required.



Bernard A. Rawlins, M.D.

BAR/

Cc: Answorth Allen, M.D./HSS
Carl Heise, M.D.


Bernard A. Rawlins, M.D.
PROGRESS NOTES

-1-

SEPTEMBER 8, 2003

ANDRZEJ CIESLIK

The patient returns today with his MRI and this shows a large disc herniation with compression of the spinal cord at that level. Given the degree of cord compression, it is my opinion that this should be decompressed. I have discussed this with and he would like to go ahead with this and Dr. Geiger is also agrees that this needs to be done because of the degree of stenosis present at the C6-7 level. The patient is aware however that this is not causing his right shoulder symptoms. The patient states today that he does have some paresthesias into the fingers affecting the third and fourth digits on the left side with numbness on occasion. The patient also has an MRI dated November 2, 2001 which shows the same herniation. However, the degree of compression that is evident on the axial views appear to be more pronounced on the these radiographs. The herniation appears to be larger with evidence of cord compression on the left side.





Robert R. Snashall
Chairman

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
PO BOX 29017
BROOKLYN, NY 11202-9017
www.web.state.ny.us
(800) 877-1373

State of New York - Workers' Compensation Board
In regard to Anderezi Cieslik, WCB Case #0015 2055

NOTICE OF DECISION

keep for your records

At the Workers' Compensation hearing held on 07/30/2003 involving the claim of Anderezi Cieslik at the Queens hearing location, Judge Elizabeth Lott made the following decision, findings and directions:

AWARD : The employer or insurance carrier is directed to pay the following awards, less payments already made by the employer or carrier, for the periods indicated below, unless employer or carrier files an appeal within 30 days after the date on which the decision was duly filed and served.

weeks	for disability over a period of	at rate	the sum of
	from	per week	
22.4	2/24/2003	\$400.00	\$8,960.00
	to		
	7/30/2003		

Carrier to continue payments at \$400.00.

FEES:

As lien on above award payable by separate check by carrier **TO CLAIMANT'S REPRESENTATIVE OR ATTORNEY:**

Sum of	To
\$125.00	Levidow, Levidow & Oberman

DECISION: Medical treatment and care, as necessary, for established sites of injury and/or conditions, is authorized. Thomas Pink is discharged and removed from notice. Case is continued.

Claimant - Anderezi Cieslik
Social Security No. - 083-66-6857
WCB Case No. - 0015 2055
Date of Accident - 09/11/2001
District Office - NYC

Employer - Gary Nelson
Carrier - *** Carrier Undetermined ***
Carrier ID No. - W000004
Carrier Case No. - 47294665-289
Date of Filing of this Decision - 08/07/2003

ATENCION:

Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, cuyo numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).



Robert R. Snashall
Chairman

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
PO BOX 29017
BROOKLYN, NY 11202-9017
www.wcb.state.ny.us
(800) 877-4461

State of New York - Workers' Compensation Board

In regard to Anderezi Cieslik, WCB Case #0015 2055

**NOTICE OF DECISION
NO INSURANCE CASE**

keep for your records

At the Workers' Compensation hearing held on 06/03/2002 involving the claim of Anderezi Cieslik at the Queens hearing location, Judge Clauderick A Cole made the following decision, findings and directions:

AWARD : The employer or insurance carrier is directed to pay the following awards, less payments already made by the employer or carrier, for the periods indicated below, unless employer or carrier files an appeal within 30 days after the date on which the decision was duly filed and served.

	for disability over a period of		at rate	
weeks	from	to	per week	the sum of
37.6	9/12/2001	6/3/2002	\$350.00	\$13,160.00
- Tentative rate.				
- Payments are to be made pursuant to section 25.1(f) without prejudice Crawford.				

Carrier to continue payments at \$350.00 TR.

FEES:

As lien on above award payable by separate check by carrier TO CLAIMANT'S REPRESENTATIVE OR ATTORNEY:

Sum of	To
\$1,200.00	Andrew Kaminski

DECISION: The claimant Anderezi Cieslik had a work related injury to the neck & right arm. The claimant's average weekly wage for the year worked before this work related injury or occupational disease is determined to be \$537.15 per C-2 without prejudice. Physical therapy authorized post operative. Surgery authorized to the neck. Great Northern Ins c/o Chubb is discharged and removed from notice. Case is continued.

*** Continued on next page ***

Claimant - Anderezi Cieslik
Social Security No. - XXXXXXXXXX
WCB Case No. - 0015 2055
Date of Accident - 09/11/2001
District Office - NYC

Employer - Gary Nelson
Carrier - *** Carrier Undetermined ***
Carrier ID No. - W000004
Carrier Case No. - 47294665-289
Date of Filing of this Decision - 06/11/2002

ATENCION:

Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, cuyo numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).



Robert R. Snashall
Chairman

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
PO BOX 29017
BROOKLYN, NY 11202-9017
www.wcb.state.ny.us
(800) 877-1373

State of New York - Workers' Compensation Board
In regard to Anderezi Cieslik, WCB Case #0015 2055

NOTICE OF DECISION

keep for your records

At the Workers' Compensation hearing held on 10/07/2002 involving the claim of Anderezi Cieslik at the Queens hearing location, Judge Elizabeth Lott made the following decision, findings and directions:

AWARD : The employer or insurance carrier is directed to pay the following awards, less payments already made by the employer or carrier, for the periods indicated below, unless employer or carrier files an appeal within 30 days after the date on which the decision was duly filed and served.

weeks	for disability over a period of	from	to	at rate per week	the sum of
5.8		8/27/2002	10/7/2002	\$165.00	\$957.00
- Tentative rate.					

Carrier to continue payments at \$165.00 TR.

FEES:

As lien on above award payable by separate check by carrier TO CLAIMANT'S REPRESENTATIVE OR ATTORNEY:

Sum of	To
\$175.00	Andrew Kaminski

DECISION: Case is closed per Rule 22. Claimant to produce an IME & EMG test results to the Board & carrier. Award is payable by National Trust c/o Crawford. No further action is planned by the Board at this time.

Claimant - Anderezi Cieslik
Social Security No. - XXXXXXXXXX
WCB Case No. - 0015 2055
Date of Accident - 09/11/2001
District Office - NYC

Employer - Gary Nelson
Carrier - *** Carrier Undetermined ***
Carrier ID No. - W000004
Carrier Case No. - 47294665-289
Date of Filing of this Decision - 10/16/2002

ATENCION:

Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, cuyo numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).